CITY OF BUFFALO

DEPARTMENT OF LAW

EXHIBIT

E

MR# [redacted] Account # [redacted] Report# 0101-0456

ERIE COUNTY MEDICAL CENTER CORPORATION
ED-Provider Report
462 Grider St.,Buffalo, NY 14215
(716) 898-3000

Patient's Name KISTNER,JAMES
Report# 0101-0456
Date of Birth: [redacted]60
Attending Physician:
Dictating Provider: REED,ESSIE M MD, (RES)
Primary Provider: NO PRIMARY CARE PROVIDER

MR#: [redacted] **/Account #:** [redacted]
Age/Sex: 56/M
Admission Date/Time:
Admitting Service:
Dictating Date/Time: 01/01/17 1158

History of Present Illness

General

ED Attending: BILLITTIER,ANTHONY J IV, MD
Tracker Chief Complaint: Facial Pain
Time seen by ED provider: 11:45

Allergies/Medications

Allergies:
Coded Allergies:
codeine (Verified Allergy, Unknown, 1/1/17)
Current Patient Meds:
DENIES

History of Present Illness

Initial Comments
The patient is a 56-year-old with a past medical history of a lumbar spinal tumor status post removal, sarcoid, and chronic renal disease male who presents in police custody due to agitation. He reportedly struck a police car breaking the side view mirror. He is extremely agitated throughout the interview repeatedly shouting that everyone in the room is a "fascist and a nazi." And that he was injured by the handcuffs applied by the police. He did also state that he fell and struck his head. He denies loss of consciousness. No neck or back pain. He was able to ambulate after the fall. He is alert, and oriented to place, time. It is difficult to ascertain whether or not he is oriented to circumstance of his arrival in the ED. He complains of mild posterior headache as well as bilateral wrist pain.
Pain Severity: 5

Past History

Past History

Past History Narrative
as per HPI

Social History

Smoking: smoker

Review of Systems

Review of Systems

ROS Narrative
constitutional: no fever/chills, no fatigue
eye: no blurred vision, no double vision
ENT: no tinnitus, no sore throat
cardiovascular: no chest pain, no palpitations
respiratory: no dyspnea, no cough
GI: no abdominal pain, no nausea/vomiting
GU: no dysuria, no hematuria
MSK: no neck pain, no joint pain

skin: no rash, no lesions
neuro: no dizziness, + headache
psych: no SI, no HI

Physical Exam
Vital Signs
Vital Signs

Vital Signs

Date Time	Temp	Pulse	Resp	B/P	Pulse Ox	O2 Delivery	O2 Flow Rate	FiO2
1/1/17 14:24	97.9	73	16	156/78				

Physical Exam
Physical Exam Narrative
Gen: no acute distress, well developed & well nourished
eye: PERRL, EOMI, normal sclera
Head: normocephalic, small abrasion over right forehead
ENT: moist mucous membranes, no erythema or exudates in oropharynx, hearing grossly normal,
neck: supple, normal ROM, nontender to palpation
respiratory: lungs clear w/normal breath sounds, no respiratory distress, no accessory muscle use
cardiac: regular rate & rhythm, no murmurs appreciated, normal peripheral pulses
abdominal: nontender, nondistended, soft, normal bowel sounds

extremities: normal ROM, normal inspection, no pedal edema
skin: warm, dry, no rashes, no lesions
psych: normal thought pattern, no hallucinations, no SI or HI, agitated
neuro: Alert, awake, oriented to person, place, and time, unable to determine the patient is oriented to circumstance, moves all extremities

Lab/Imaging/EKG Results
Laboratory Results

LAB-8h RESULTS

Test	1/1/17 13:30	1/1/17 14:50
Acetaminophen Level	< 15.0mcg/mL (15-30) L	
Anion Gap	13mmol/L (7-18)	
Barbiturates	< 0.03mcg/mL	
Basophils # (Auto)	0.0x10e9/L (<0.2)	
Basophils (%) (Auto)	0.3% (0.0-2.0)	
Benzodiazepines Screen	< 3.0ng/mL	
Blood Urea Nitrogen	19mg/dL (6-20)	
Calcium Level	9.8mg/dL (8.4-10.2)	
Carbon Dioxide Level	24mmol/L (19-30)	
Chloride Level	106mmol/L (96-108)	
Creatinine	1.1mg/dL (0.7-1.2)	
Eosinophils # (Auto)	0.1x10e9/L (<0.7)	
Eosinophils (%) (Auto)	0.9% (0.5-11.0)	
Estimat Glomerular Filtration Rate	69.2mL/min	
Estimated GFR (African American)	83.9mL/min	

MR# [redacted] Account # [redacted] Report # 0101-0456

Ethyl Alcohol Level	< 10.0mg/dL (<10.0)	
Glucose Level	180mg/dL (74-99) H	
Hematocrit	42.1% (42.0-52.0)	
Hemoglobin	14.1g/dL (14.0-18.0)	
Lymphocytes # (Auto)	1.1x10e9/L (1.0-4.0)	
Lymphocytes (%) (Auto)	13.9% (16.0-51.0) L	
Mean Corpuscular Hemoglobin	31.2pg (27.0-31.0) H	
Mean Corpuscular Hemoglobin Concent	33.5g/dL (33.0-37.0)	
Mean Corpuscular Volume	93.1fL (80.0-99.0)	
Mean Platelet Volume	11.7fL (7.4-10.4) H	
Monocytes # (Auto)	0.6x10e9/L (0.1-1.0)	
Monocytes (%) (Auto)	7.3% (1.7-12.0)	
Neutrophils # (Auto)	5.9x10e9/L (1.4-7.0)	
Neutrophils (%) (Auto)	76.8% (40.0-75.2) H	
Nucleated Red Blood Cells #	0.0x10e9/L (0-0)	
Nucleated Red Blood Cells %	0.0/100 WBC (0-0)	
Platelet Count	264x10e9/L (130-400)	
Potassium Level	4.2mmol/L (3.3-5.1)	
RDW Coefficient of Variation	12.4% (11.5-14.5)	
Red Blood Count	4.52x10e12/L (4.70-6.10) L	
Red Cell Distribution Width	42.2fL (35.1-46.3)	
Salicylates Level	< 2.6mg/dL (<30)	
Sodium Level	143mmol/L (133-145)	
White Blood Count	7.6x10e9/L (4.8-10.8)	

Imaging Results
CT
COMPARISON: 6, 10, 2009.

FINDINGS:

No abnormal area of attenuation is seen from acute infarction, hemorrhage, or mass. The midline structures are not shifted and there are no extra-axial collections. The ventricular system is not dilated in an obstructed configuration. Skull base and calvarium are unremarkable. Included paranasal sinuses and mastoid air cells are clear.

IMPRESSION: No acute infarction,hemorrhage or mass . No significant injury to brain.

MR# [redacted] Account # [redacted] Report# 0101-0456

Medical Decision Making

Medical Decision Making

Patient is a 56-year-old male presenting with ultimate mental status after an altercation with police. Although on my initial interview is extremely agitated and aggressive, during the evaluation by the attending the patient was calm and able to provide history. The hip he stated at that time he was simply trying to get the police attention. The details of the altercation were not provided by the patient. Workup is unremarkable, and CT scan is negative for acute injury or hemorrhage. He will be stable for discharge to police custody

Re-evaluation

Time Re-evaluated: 15:00
Re-evaluation: Improved
Re-evaluation Note

Patient's mental status is much improved. He is alert, oriented,, and able to provide an appropriate history. He notes that he is willing to be discharged to police custody to "get this over with more quickly." I do not believe he warrants CPEP evaluation S mental status is baseline, and he has had no questions or concerns of suicidality.

The patient's wife was also alerted to his condition and no questions were answered satisfactorily.

ED Diagnoses

Diagnoses

Diagnoses:

Primary Impression:
Forehead abrasion
Encounter type: initial encounter **Qualified Code:** S00.81XA - Abrasion of other part of head, initial encounter
Additional Impression:
Closed head injury
Encounter type: initial encounter **Qualified Code:** S09.90XA - Unspecified injury of head, initial encounter

Disposition

Post ED Plan

Post ED Plan for patient: patient discharged from ED
Condition: Good

Discharge Disposition

Post ED Plan for patient: other (discharged to police custody)

ED Discharge

Post ED Plan

Discharge Disposition: other (sugars police custody)
Condition: Good

Discharged from ED

Diagnoses:

Primary Impression:
Forehead abrasion
Encounter type: initial encounter **Qualified Code:** S00.81XA - Abrasion of other part of head, initial encounter
Additional Impression:
Closed head injury
Encounter type: initial encounter **Qualified Code:** S09.90XA - Unspecified injury of head, initial encounter

Counseled patient/family: regarding diagnosis, regarding tx plan, on discharge plan

Follow Up/Referral

Clinic patient referred to: Primary Medical Doctor
Patient Instructions: Concussion (ED)
Follow Up Instructions:
You seen today for concussion.
Please follow-up with your primary care provider. If you do not have a

primary care provider please see one of the phone numbers listed above and call to establish primary care. If your symptoms worsen, and you are unable to see a primary care physician, return to the Emergency Department

Return to ED

Return to ED if (symptoms):
Turn to the emergency department experience persistent headaches, visual changes, numbness or weakness in her arms or legs, the ambulating, or change in urinary or bowel habits

DRAGON DISCLAIMER: Dragon voice-recognition software may have been used to prepare this typewritten note. Although each note is personally scanned for syntactic or grammatical errors, unintended but conspicuous translational errors can occur. Please contact ECMC if there are any questions about the contents of this note.

REED,ESSIE M MD, (RES) Jan 1, 2017 11:58

Attn Physician:

<Electronically signed by ESSIE M REED MD, (RES)>, 01/01/17 1514
<Electronically signed by ANTHONY J BILLITTIER IV, MD>, 01/08/17 1522

,

<Electronically signed by ANTHONY J BILLITTIER IV, MD>
01/08/17 1522

PC Physician: NO PRIMARY CARE PROVIDER
Ref Physician:
Copies To:
~

ERIE COUNTY MEDICAL CENTER
HEALTHCARE NETWORK

462 Grider Street Buffalo, New York 14215

DEPARTMENT OF IMAGING SERVICES

PT NAME: KISTNER,JAMES
MRN: [redacted]
DOB: [redacted]60 Sex: M
Service Date: 01/01/17 **Time:** 1158
Requisition No: 17-0000154
Procedures:
0101-0082 CT/CT Head Wo IV

Pt Type: DEP ER **Pt Location:** ER
Attending:
Referring: REED, ESSIE M MD, (RES)
Primary Care: NO PRIMARY CARE PROVIDER
Account Number: [redacted]
REPORT NO: 0101-0131

TITLE: CT HEAD

INDICATION: Injury to head. Patient had altercation with police.

TECHNIQUE: Contiguous axial CT images from the skullbase to vertex were obtained without contrast. Up-to-date CT equipment, automated exposure control, and iterative reconstruction techniques were employed for radiation dose reduction. CTDIvol: 49.2 mGy. DLP: 938 mGy-cm.

COMPARISON: 6, 10, 2009.

FINDINGS:

No abnormal area of attenuation is seen from acute infarction, hemorrhage, or mass. The midline structures are not shifted and there are no extra-axial collections. The ventricular system is not dilated in an obstructed configuration. Skull base and calvarium are unremarkable. Included paranasal sinuses and mastoid air cells are clear.

IMPRESSION: No acute infarction,hemorrhage or mass . No significant injury to brain.

Films reviewed and dictated by:	GREGORY P PHILLIES MD 01/01/17 1326
Signed by:	<Electronically signed by GREGORY P PHILLIES MD in OV>
Sign date / time:	01/01/17 1329

01/01/17 1326 XXX

Copies To: NO PRIMARY CARE PROVIDER;
Printed:

ADDENDUM

In accordance with ECMC's quality improvement initiative, this head CT study was secondarily reviewed and I Concur with the above interpretation.

PT NAME: KISTNER,JAMES
DEPARTMENT OF IMAGING SERVICES

MEDICAL RECORD NUMBER: [redacted]
REPORT NO: 0101-0131

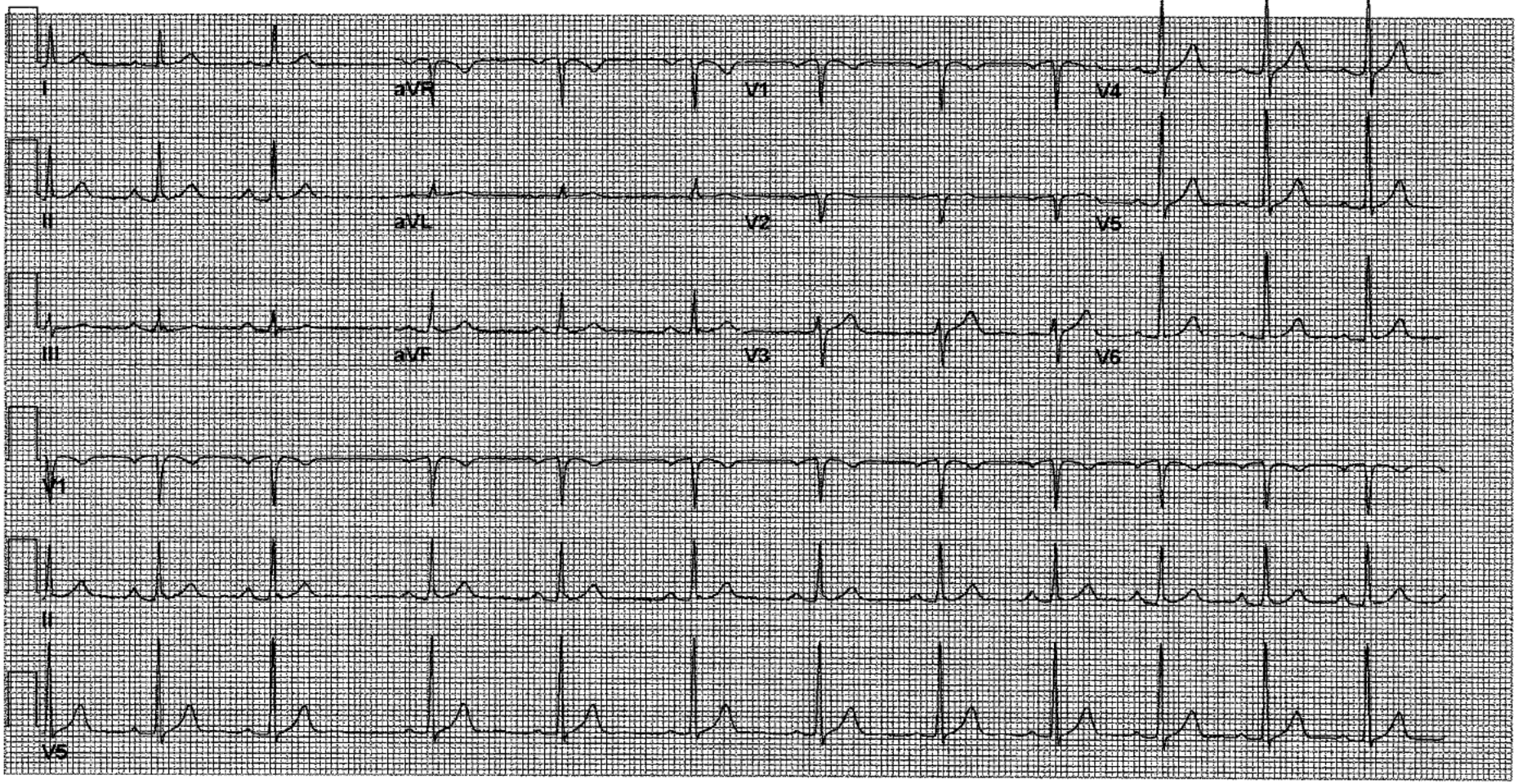
Addendum dictated by: MICHAEL F TABONE, DO 01/03/17 1724
Addendum signed by: <Electronically signed by MICHAEL F TABONE DO in OV>
Addendum sign date / time: 01/03/17 1726
Addendum Number: 1 Released on: 01/03/17 1726

KISTNER, JAMES **ID:** [redacted] **01-JAN-2017 13:34:42 ERIE COUNTY MEDICAL CENTER-ED ROUTINE RETRIEVAL**

03-APR-1960 (56 yr)	Vent. rate	70	BPM	Sinus rhythm with marked sinus arrhythmia
Male Caucasian	PR interval	180	ms	Otherwise normal ECG
199lb	QRS duration	92	ms	When compared with ECG of 29-MAY-2009 08:35,
Room:	QT/QTc	364/393	ms	No significant change was found
Loc:17	P-R-T axes	71 48	47	Confirmed by ORLICK MD, ARTHUR (21) on 1/1/2017 4:50:51 PM

Technician: JMC
Test ind:Chest pain/angina

Confirmed By: ARTHUR ORLICK MD



25mm/s 10mm/mV 40Hz 9.0.4 12SL 239 CID: 24

EID:21 EDT: 16:50 01-JAN-2017 ORDER: E01010024 ACCOUNT: [redacted]

MR# [redacted] Account # [redacted] Report# 0101-0583

ERIE COUNTY MEDICAL CENTER CORPORATION
ED-Attending Supervising Note
462 Grider St.,Buffalo, NY 14215
(716) 898-3000

Patient's Name KISTNER,JAMES
Report# 0101-0583
Date of Birth: [redacted]60
Attending Physician:
Dictating Provider: BILLITTIER,ANTHONY J IV, MD
Primary Provider: NO PRIMARY CARE PROVIDER

MR#: [redacted] **/Account #:** [redacted]
Age/Sex: 56/M
Admission Date/Time:
Admitting Service:
Dictating Date/Time: 01/01/17 1445

ED-Attending Supervising Note
Attestation
1/1/17 14:33

I personally interviewed and examined the patient and discussed the patient's care with the resident/physician extender. I reviewed the resident's/physician extender's note and agree with their findings and plan.

Attending Note

Patient was seen at 1337 hrs. Patient is a 56-year-old white male with a past medical history significant for a tumor removed from his lumbar spine, renal failure, sarcoidosis of his lungs with a medic pneumothorax from a bronchoscopy, kidney stone, lumbago, lipoma, post laminectomy syndrome, bursitis, osteoarthritis and alcohol abuse who presented with Buffalo police after he hit his head on the ground. Patient states he owns rental properties in his neighborhood. He states he and his son put an eviction notice on one of them earlier today. They subsequently noticed police near the house. He approached the police to inquire why they were called. He states that the first lease officer said he does not have time to talk to the patient and drove away. He then approached the second police car and stated he thinks he slipped on ice and hit his head on the ground. He describes falling forward. He claims he reamers hitting the ground, but does suggest he had an amnestic period although he remembers calling for his son. He complains of a headache now. Police report that the patient walked up to their car and purposefully threw himself onto the ground. They state that the patient had no loss of consciousness and was awake and alert throughout the event. Further, they state that the patient appeared to be feigning unresponsiveness in the back of the patrol car, but they noticed that his eyelids were blinking. Patient complains of pain over the back of his head. He states he also has tingling of both hands and especially thumbs probably from the handcuffs. He states that he had nausea and takes he vomited a little in the patrol car, but states his nausea is improving. Patient otherwise denies any visual changes, dental problems, focal weakness, chest pain, shortness of breath, abdominal pain, change in his chronic low back pain, extremity pain or neck pain. Patient admits to feeling depressed, but denies any suicidal or homicidal ideations. He is unsure of the date of his last tetanus shot. He lives with his sons. He is not employed externally. He does have a primary care provider. Patient states he has seen a psychiatrist in the past, but not been under treatment for a long time. Patient states he allergic to codeine. He admits to being a smoker. He states he has had no alcohol to drink since 1999. He denies drug use.

Patient is a white male who appears slightly bizarre at times. However, he is otherwise alert, oriented and oriented ×3. Head is normocephalic. There is a slight abrasion over the mid forehead. There is mild tenderness. There is also mild bilateral jaw tenderness. Dentition are intact. Trachea is mid line. Pupils are equal, round and reactive to light. Extraocular muscles are intact. TMs are without evidence of hemotympanum. Chest is nontender. Breath sounds are equal. Lungs are clear. Back is mildly diffusely tender over the thoracic vertebrate. There is also tenderness over the lumbar vertebrae, but the patient states that is chronic. There are erythematous rings around both wrists. She has full sensation in all extremities. He has 5 over 5 strength in all extremities. Pulses are intact in all extremities. Cranial nerves II-12 are intact.

CBC is unremarkable. BMP is significant only for glucose 180. Serum tox is negative. CT of the patient's brain was interpreted by the radiologist to show no significant injury. EKG shows normal sinus rhythm with sinus arrhythmia with QTC 393 ms and no acute changes by my interpretation. Patient declines pain medications. We will administer a tetanus shot and ambulate the patient. If he ambulates well, he will be safe for discharge with police. We'll continue serial evaluations.

Personally performed: supervision of care, PMH, physical exam, MDM

MR# [redacted] Account # [redacted] Report# 0101-0583

Personally reviewed: CT results, EKG results, lab results
Case discussed with: resident

ED Diagoses

Diagnoses:

Primary Impression:
Closed head injury
Encounter type: initial encounter **Qualified Code:** S09.90XA - Unspecified injury of head, initial encounter
Additional Impression:
Forehead abrasion
Encounter type: initial encounter **Qualified Code:** S00.81XA - Abrasion of other part of head, initial encounter

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BILLITTIER,ANTHONY J IV, MD Jan 1, 2017 14:45

Attn Physician:

<Electronically signed by ANTHONY J BILLITTIER IV, MD>, 01/08/17 1522

,

,

PC Physician: NO PRIMARY CARE PROVIDER
Ref Physician:
Copies To:
~

Name: KISTNER,JAMES **Date of Birth:** [redacted]60
Med Rec #: [redacted] **Age:** 56 M
Visit #: [redacted] **Insurance:** SP
Arrival: 01/01/17 1135 **Physician:** BILLITTIER,ANTHONY J IV, MD

Status Event History:

01/01/17	1135	Received
	1142	Triaged
	1153	In Room
	1207	CT is ready to accept patient
	1309	In Room

Vital Signs (Most Recent)

Date	01/01/17	01/01/17					
Time	1142	1424					
Temp	98.6	97.9					
BP	153/78	156/78					
Pulse/HR	113	73					
Cardiac Rhythm							
Resp Rate	18	16					
SpO2	95	97					
Oxygen							

ER Initial RN Assessment

01/01/17 1159 ER Initial Assessment

ALEXANDRIA K POWLEY RN

Nursing Note:

Summary of Assessment Findings

56 y/o male to ED in custody of BPD after throwing himself backward onto police vehicle while it was stopped then throwing himself onto ground. has c/o 7/10 pain in posterior head and left elbow. abrasion noted to center of anterior forehead, skin intact. full ROM noted to left elbow, no edema or injury noted. pt is uncooperative, screaming in room, calling police officers "fascists". did cooperate momentarily with writer and provider to give a partial recount of what happened. when dr left room pt began screaming again and refusing treatment stating "i just want to go to jail now. i don't want to be here anymore". also refused to sign registration paperwork and consent to treat. provider notified. BPD at bedside, have all pt's belongings in their custody. awaiting further orders.

Triage Process

Patient directly bedded (y/n):	N

Pain

Pain Location:	posterior head
Pain Severity:	8

Patient Weight

Weight (pounds)	200
Weight (Calculated Grams)	90718.474
Weight (Calculated Kilograms)	90.718

Respiratory System Assessment

Respiratory Assessment:	Clear bilaterally

Cardiovascular System Assessment

Cardiovascular Assessment:	Hypertensive Tachycardia

Name: KISTNER,JAMES **Date of Birth:** [redacted]60
Med Rec #: [redacted] **Age:** 56 M
Visit #: [redacted] **Insurance:** SP
Arrival: 01/01/17 1135 **Physician:** BILLITTIER,ANTHONY J IV, MD

Endocrine System Assessment

Endocrine Assessment:	None Reported

Neurological System Assessment

Neurological Assessment:	Head Injury
Dysphagia Screen:	Pass
Patient Orientation:	Person
	Place
	Time
Glasgow Coma Scale Eye Opening	Spontaneous
Glasgow Coma Scale Motor	Obeys Commands
Glasgow Coma Scale Verbal	Oriented
Glasgow Coma Scale Total	15
Pupil Equality	Equal
Right Pupil Size	3
Right Pupil Reaction	Brisk
Left Pupil Size	3
Left Pupil Reaction	Brisk

Behavior Assessment

Behavior Assessment:	Anxious
	Agitated/Combative
	Other - see comment below
Lethality Risk:	No

Sensory System Assessment

Vision Assessment:	None Reported
Hearing Assessment:	None Reported
English Speaking:	Y

Oral/Nasal System Assessment

Oral Assessment:	None Reported
Nasal Assessment:	None Reported

Gastrointestinal System Assessment

Gastrointestinal Assessment:	Nausea

Genitourinary System Assessment

Genitourinary Assessment:	None Reported
Reproductive Assessment:	None Reported

Musculoskeletal System Assessment

Musculoskeletal Assessment:	Pain
	Positive CMS
Extremity Temp	Warm
Extremity Color	Pink
Musculoskeletal additional findings:	pain to posterior head and left elbow s/p fal

Skin Assessment

Skin Assessment:	Abrasion
Pressure Ulcer Present:	N
Skin Note:	see nurses note

Habits

Name: KISTNER,JAMES **Date of Birth:** [redacted]60
Med Rec #: [redacted] **Age:** 56 M
Visit #: [redacted] **Insurance:** SP
Arrival: 01/01/17 1135 **Physician:** BILLITTIER,ANTHONY J IV, MD

Nicotine Use	Y
Smoking Status:	Current every day smoker
Alcohol Use	N
Substances Used	N

History of Physical/Sexual Abuse/Neglect

Physical Abuse	Denied
Sexual Abuse	Denied
Domestic Violence	Denied
Emotional Abuse/Neglect	Denied
Advocate Called:	N

Immunizations

Immunizations up-to-date:	Unknown

Fall Risk Factors

Confusion/Disorientation/Impulsivity	Yes
SCORE (Fall Risk 1)	0
Symptomatic Depression	No
Score Fall Risk 2	0
Altered Elimination	No
Score Fall Risk 3	0
Dizziness/Vertigo	No
Score Fall Risk 4	0
Gender (Male)	Yes
Score FallRisk 5	0
Administered Anticonvulsants	No
Score Fall Risk 6	0
Administered Benzodiazepines	No
Score Fall Risk 7	0
Get up and Go Test	Able to rise-Single Move
Calculated Fall Risk	5
Clinical Fall Risk	YES
Fall Risk	Falling Star Program

Family Notification

Family Notification	Unable
Family note:	pt in custody

Patient Safety

Safety Measures:	Patient ID band on Call light within reach Side rails raised Stretcher in low position

HIV Screen

Was HIV test offered:	Y
Date HIV test was offered:	20170101
Reason HIV test not offered:	Patient Refused
Verbal consent obtained:	N

Name: KISTNER,JAMES **Date of Birth:** [redacted]60
Med Rec #: [redacted] **Age:** 56 M
Visit #: [redacted] **Insurance:** SP
Arrival: 01/01/17 1135 **Physician:** BILLITTIER,ANTHONY J IV, MD

01/01/17 1159 ER Sepsis Screen ***ALEXANDRIA K POWLEY, RN***

RN Screening:
Temperature > 38.5 C (101.3 F) or < 36 C (96.8 F): N
Tachycardia > 90bpm: Y
Tachypnea > 20bpm: N
Sepsis Screening Result:
Result: Negative
Positive for Sepsis: --

RN Re-Assessment

01/01/17 1330 ER RN Re-Assessment ***ALEXANDRIA K POWLEY, RN***

Re-assessment:
Nurse Re-assessment pt refusing cardiac monitoring. provider aware.

01/01/17 1420 ER RN Re-Assessment ***ALEXANDRIA K POWLEY, RN***

Pain:
Pain Location: refusing
Pain Severity: 0
Re-assessment:
Nurse Re-assessment pt lying in bed, BPD at bedside. a&o x3, calm but not cooperative at this time. VSS, easy work of breathing. refusing to tell writer if he is in pain or needs anything. no acute discomfort or distress noted. MAE. ambulates in room with steady gait independently. continues to call writer derogatory names. also continues to refuse cardiac monitoring. IVF running. provider notified of pt's refusals and status. awaiting further orders at this time.

Triage Assessment

01/01/17 1142 Triage Screening ***ADRIANNE A MATTINA, RN***

Temperature:
Temperature (Fahrenheit) 98.6
Heart Rate and Respiratory Rate:
Heart Rate 113
Respiratory Rate 18
Blood Pressure:
Blood Pressure Systolic 153
Blood Pressure Diastolic 78
SAO2:
SAO2 95
History:
Medical Conditions: SARCOIDOSIS, TUMOR REMOVAL CHEST WALL X3 (LAST 6/9/09)
PATIENT HOME MEDS DENIES
Pain:
Pain Location: FACIAL
Pain Severity: 5
Patient Arrival:
Mode of Arrival Police
Travel:
Travel in last 3 weeks? N
General:
Transfer In? N
HOSPICE? N
HCP/DNR:

Name: *KISTNER,JAMES* **Date of Birth:** [redacted]50
Med Rec #: [redacted] **Age:** *56 M*
Visit #: [redacted] **Insurance:** *SP*
Arrival: *01/01/17 1135* **Physician:** *BILLITTIER,ANTHONY J IV, MD*

Do Not Resuscitate Order? N
MOLST Form With Patient ? N
Health care proxy? N
Limitation of Treatment ? N
Triage Nurse Assessment (4 Lines Max):
Triage Assessment WITH POLICE AFTER THROWING HIMSELF INTO A POLICE CAR AND THEN ONTO THE GROUND C/O HEAD AND FACE PAIN. WILL NOT ANSWER QUESTIONS
Immediate Evaluation:
Pt. sent for immediate MD evaluation: N
Behavioral Health Evaluation:
Patient sent directly to CPEP: N
Chief Complaint/Priority:
Current Chief Complaint Facial Pain
EDM Priority 3 - Urgent

Hydration, Blood (Most Recent)

ER Saline Lock/Hydration

Date	01/01/17					
Time	1332					

IV Intake

Placed PTA:						
Time line was placed:	1332					
*Location Modifier:	Left					
*IV Site:	Antecubit					
*Catheter Type	Periphera					
Catheter Size:	20					
Time IV fluid was hung:	1332					
IV Number	1					
*Type of **HYDRATION** fluid:	0.9% NS					
IV Rate:	999					
Stop Time (IV)						
*IV Hydration Amount Infused:						
IV Fluids Continued:						

EMS Fluid

EMS IV Fluid Volume PTA:						

Allergies

Allergy/Adverse Reaction	Type	Severity	Date
codeine	Allergy	Unknown	01/01/17

Medications

Ordered	Medication	Provider
01/01/17 1206	Sodium Chloride 0.9% 1000 ML 0 MLS/HR 0 SEC BAG IV/.QOM/ONE Bolus	REEDESS
01/01/17 1445	Tetanus/Diphth/Pertuss (Tdap) 0.5 ML INJECTION IM/ONCE/ONE *** SHAKE WELL *** VACCINES ARE GOOD FOR 24 HOURS AT ROOM TEMPERATURE. DO NOT USE AFTER:	BILAN

Name: KISTNER,JAMES **Date of Birth:** [redacted]60
Med Rec #: [redacted] **Age:** 56 M
Visit #: [redacted] **Insurance:** SP
Arrival: 01/01/17 1135 **Physician:** BILLITTIER,ANTHONY J IV, MD

Medication

Sch Date-Time / Doc Date-Time	Ordered Dose / Given - Reason	Admin Dose / Site	User
Sodium Chloride 0.9% 1,000 ML (Normal Saline 1,000 ML) IV/.Q0M/ONE			
01/01/17-1150	999 MLS/HR		
01/01/17-1334	Y		ALEXANDRIA K POWLEY

Acknowledgements

Ack Date-Time	User
01/01/17-1330	ALEXANDRIA K POWLEY

Sch Date-Time / Doc Date-Time	Ordered Dose / Given - Reason	Admin Dose / Site	User
Tetanus/Diphtheria/Pertussis 0.5 ML Inj (Tdap Adult) (Boostrix Inj) IM/ONCE/ONE			
01/01/17-1445	0.5 ML	0 ML	
01/01/17-1525	N	.Medication Ref	JAMIE L WOOD

Acknowledgements

Ack Date-Time	User
01/01/17-1519	JAMIE L WOOD

Thera. Infusions (Most Recent)

I&O (Full History)

01/01/17 1332 ER Saline Lock/Hydration ***ALEXANDRIA K POWLEY, RN***

IV Intake:
Time line was placed: 1332
Location Modifier: Left
IV Site: Antecubital
Catheter Type Peripheral IV
Catheter Size: 20
Time IV fluid was hung: 1332
IV Number 1
Type of **HYDRATION fluid:** 0.9% NS
IV Rate: 999

Vitals (Full History)

01/01/17 1424 ER Vital Signs ***SEAN M HALL***

Temperature:
Temperature (Fahrenheit) 97.9
Temperature Source: Oral
Heart Rate and Respiratory Rate:
Heart Rate 73
Respiratory Rate 16
Blood Pressure:
Blood Pressure Position Lying
Blood Pressure Systolic 156
Blood Pressure Diastolic 78
SAO2:
SAO2 97
O2 Type: Room Air
Refused:
Refused Vital Signs N

Name: *KISTNER,JAMES* **Date of Birth:** [redacted]*60*
Med Rec #: [redacted] **Age:** *56 M*
Visit #: [redacted] **Insurance:** *SP*
Arrival: *01/01/17 1135* **Physician:** *BILLITTIER,ANTHONY J IV, MD*

Lab Results

===== GENERAL =====

Test	Date	Time	Result		Reference	Units
NA	1/1/17	1330	143		(133-145)	mmol/L
K	1/1/17	1330	4.2		(3.3-5.1)	mmol/L
CL	1/1/17	1330	106		(96-108)	mmol/L
CO2	1/1/17	1330	24		(19-30)	mmol/L
GAP	1/1/17	1330	13		(7-18)	mmol/L
GLUC	1/1/17	1330	160	H	(74-99)	mg/dL
CREAT	1/1/17	1330	1.1		(0.7-1.2)	mg/dL
eGFR	1/1/17	1330	69.2(A)			mL/min

(A) For full interpretive data see eGFR African American interpretive comment.

eGFR African Am	1/1/17	1330	83.9(B)			mL/min

(B) INTERPRETIVE DATA FOR eGFR

The eGFR is estimated using the abbreviated MDRD Study equation based on creatinine (IDMS calibrated), age, gender and ethnicity. The eGFR for both Non-African American and African American ethnicities are provided. Interpretation applies to adults only. Estimates of GFR assume serum creatinine is stable.

>90 Normal
60-90 Possible Chronic Kidney Disease (CKD)
30-59 Stage 3 CKD
15-29 Stage 4 CKD
<15 Kidney failure

eGFR 60-90: Possible Chronic Kidney Disease (CKD). Currently, the presence of CKD can only be established on the basis of the GFR alone when GFR is lower than 60mL/min. For GFR >60mL/min there must be independent evidence of a kidney problem, as defined by abnormalities of blood and urine testing (hematuria, proteinuria) or abnormalities on kidney imaging. An eGFR of 60-90mL/min can be seen as part of the "normal" aging process.
Reference: Nat'l Kidney Foundation.K/DOQI.Am J.Kid Dis 39;S1-S200,2002.

BUN	1/1/17	1330	19		(6-20)	mg/dL
CA	1/1/17	1330	9.8		(8.4-10.2)	mg/dL

===== THERAPEUTIC DRUG MONITORING =====

Test	Date	Time	Result	Reference	Units

Name: *KISTNER,JAMES* **Date of Birth:** [redacted] *60*
Med Rec #: [redacted] **Age:** *56 M*
Visit #: [redacted] **Insurance:** *SP*
Arrival: *01/01/17 1135* **Physician:** *BILLITTIER,ANTHONY J IV, MD*

==== THERAPEUTIC DRUG MONITORING (continued) ====

Test	Date	Time	Result	Reference	Units
ETHANOL	1/1/17	1330	< 10.0 (C)	(<10.0)	mg/dL

(C) RED top tube received and assayed for Ethanol.
See also (D)

SALICYLATE	1/1/17	1330	< 2.6	(<30)	mg/dL
ACETAMIN	1/1/17	1330	< 15.0 L	(15-30)	mcg/mL

==== TOXICOLOGY SCREEN BLOOD ====

Test	Date	Time	Result	Reference	Units
BARBS	01/01/17	1330	< 0.03 (D)		mcg/mL

(D) INTERPRETIVE DATA FOR BARBS

All barbiturate class drug results are preliminary.
The concentrations are an estimate due to the different reactivity of the various barbiturates and/or their metabolites with the secobarbital polyclonal antibody.

BENZOS	01/01/17	1330	< 3.0 (E)		ng/mL

(E) INTERPRETIVE DATA FOR BENZOS

Benzodiazepine class drug results are preliminary.
Concentrations are an estimate due to different reactivity of various benzodiazepines and/or their metabolites with the nordiazepam polyclonal antibody.

==== TOXICOLOGY SCREEN URINE ====

Test	Date	Time	Result	Reference	Units

Name: *KISTNER,JAMES* **Date of Birth:** [redacted]*60*
Med Rec #: [redacted] **Age:** *56 M*
Visit #: [redacted] **Insurance:** *SP*
Arrival: *01/01/17 1135* **Physician:** *BILLITTIER,ANTHONY J IV, MD*

==== TOXICOLOGY SCREEN URINE (continued) ====

Test	Date	Time	Result	Reference	Units
UR AMPHET	01/01/17	1450	NEGATIVE(F)	(NEGATIVE)	
UR BARBS	01/01/17	1450	NEGATIVE(F)	(NEGATIVE)	

(F) INTERPRETIVE DATA FOR BARBSU
Cutoff: 200 ng/mL

A positive result is preliminary and indicates the presence of a single barbiturate in concentrations greater than the cutoff or combined reactivity of several barbiturates.

UR BENZOS	01/01/17	1450	NEGATIVE(G)	(NEGATIVE)	

(G) INTERPRETIVE DATA FOR BENZOSU

Cutoff: 100 ng/mL

A positive result is preliminary and indicates the presence of a single benzodiazepine in concentrations greater than the cutoff or combined reactivity of several benzodiazepines.

UR CANNABS	01/01/17	1450	POSITIVE(H) *	(NEGATIVE)	

(H) INTERPRETIVE DATA FOR CANNABS

Cutoff: 50 ng/mL

A positive result is preliminary and indicates the presence of a single cannabinoid in concentrations greater than the cutoff or the combined reactivity of parent drug and/or metabolites.

UR COCAINE	01/01/17	1450	NEGATIVE(I)	(NEGATIVE)	

(I) INTERPRETIVE DATA FOR COCAINE
Cutoff: 300 ng/mL

A positive result is preliminary and indicates the presence of benzoylecgonine in concentrations greater than the cutoff or the combined reactivity of parent drug and/or metabolite.

Name: KISTNER,JAMES **Date of Birth:** [redacted]60
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Visit #: [redacted] **Insurance:** SP
Arrival: 01/01/17 1135 **Physician:** BILLITTIER,ANTHONY J IV, MD

==== TOXICOLOGY SCREEN URINE (continued) ====

Test	Date	Time	Result	Reference	Units
UR METHADONE	01/01/17	1450	NEGATIVE(J)	(NEGATIVE)	
OPIATES	01/01/17	1450	NEGATIVE(J)	(NEGATIVE)	

(J) INTERPRETIVE DATA FOR OPIATES
Cutoff: 300 ng/mL

A positive result is preliminary and indicates the presence of Opiates in concentrations greater than the cutoff or the combined reactivity of drug and/or metabolites.

PCP	01/01/17	1450	NEGATIVE(K)	(NEGATIVE)	

(K) INTERPRETIVE DATA FOR PCP
Cutoff: 25 ng/mL

A positive result is preliminary and indicates the presence of phencyclidine in concentrations greater than the cutoff or the combined reactivity of parent drug and/or metabolites.

PROPOX	01/01/17	1450	NEGATIVE(L)	(NEGATIVE)	

(L) INTERPRETIVE DATA FOR PROPOX
Cutoff: 300 ng/mL

A positive result is preliminary and indicates the presence of propoxyphene in concentrations greater than the cutoff or combined reactivity of parent drug and/or metabolites.

UR OXYCODONE	01/01/17	1450	NEGATIVE(M)	(NEGATIVE)	

(M) INTERPRETIVE DATA FOR OXYCODONE
Cutoff: 100 ng/mL

A positive result is preliminary and indicates the presence of oxycodone in concentrations greater than the cutoff or the combined reactivity of parent drug and/or metabolites.

==== CBC ====

Test	Date	Time	Result		Reference	Units
WBC	1/1/17	1330	7.6		(4.8-10.8)	x10e9/L
RBC	1/1/17	1330	4.52	L	(4.70-6.10)	x10e12/L
HGB	1/1/17	1330	14.1		(14.0-18.0)	g/dL
HCT	1/1/17	1330	42.1		(42.0-52.0)	%
MCV	1/1/17	1330	93.1		(80.0-99.0)	fL
MCH	1/1/17	1330	31.2	H	(27.0-31.0)	pg
MCHC	1/1/17	1330	33.5		(33.0-37.0)	g/dL

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Arrival: *01/01/17 1135* **Physician:** *BILLITTIER,ANTHONY J IV, MD*

==== CBC (continued) ====

Test	Date	Time	Result		Reference	Units
RDW CV	1/1/17	1330	12.4		(11.5-14.5)	%
RDW SD	1/1/17	1330	42.2		(35.1-46.3)	fL
PL CT	1/1/17	1330	264		(130-400)	x10e9/L
MPV	1/1/17	1330	11.7	H	(7.4-10.4)	fL

==== DIFFERENTIAL, AUTOMATED ====

Test	**Date**	**Time**	**Result**		**Reference**	**Units**
BASO%	1/1/17	1330	0.3		(0.0-2.0)	%
EOS%	1/1/17	1330	0.9		(0.5-11.0)	%
NEUT%	1/1/17	1330	76.8	H	(40.0-75.2)	%
LYMPH%	1/1/17	1330	13.9	L	(16.0-51.0)	%
MONO%	1/1/17	1330	7.3		(1.7-12.0)	%
NRBC%	1/1/17	1330	0.0		(0-0)	/100 WBC
BASO#	1/1/17	1330	0.0		(<0.2)	x10e9/L
EOS#	1/1/17	1330	0.1		(<0.7)	x10e9/L
NEUT# (AUTO)	1/1/17	1330	5.9		(1.4-7.0)	x10e9/L
LYMPH#	1/1/17	1330	1.1		(1.0-4.0)	x10e9/L
MONO#	1/1/17	1330	0.6		(0.1-1.0)	x10e9/L
NRBC# ABS	1/1/17	1330	0.0		(0-0)	x10e9/L

Name: KISTNER,JAMES **Date of Birth:** [redacted]60
Med Rec #: [redacted] **Age:** 56 M
Visit #: [redacted] **Insurance:** SP
Arrival: 01/01/17 1135 **Physician:** BILLITTIER,ANTHONY J IV, MD

Specimen Result Verified Dates and Times.

Specimen	Test/Procedure	Collected	Verified	Hours
0101:C00233S	NA	01/01/17 1330	01/01/17 1412	0.7
0101:C00233S	K	01/01/17 1330	01/01/17 1412	0.7
0101:C00233S	CL	01/01/17 1330	01/01/17 1412	0.7
0101:C00233S	CO2	01/01/17 1330	01/01/17 1412	0.7
0101:C00233S	ANION GAP	01/01/17 1330	01/01/17 1412	0.7
0101:C00233S	GLUC	01/01/17 1330	01/01/17 1412	0.7
0101:C00233S	CREAT	01/01/17 1330	01/01/17 1412	0.7
0101:C00233S	GFR	01/01/17 1330	01/01/17 1412	0.7
0101:C00233S	eGFR African Am	01/01/17 1330	01/01/17 1412	0.7
0101:C00233S	BUN	01/01/17 1330	01/01/17 1412	0.7
0101:C00233S	CA	01/01/17 1330	01/01/17 1412	0.7
0101:CT00025S	ETHANOL	01/01/17 1330	01/01/17 1439	1.1
0101:CT00025S	SALICYLATE	01/01/17 1330	01/01/17 1439	1.1
0101:CT00025S	ACETAMIN	01/01/17 1330	01/01/17 1439	1.1
0101:CT00025S	BARBS	01/01/17 1330	01/01/17 1439	1.1
0101:CT00025S	BENZOS	01/01/17 1330	01/01/17 1439	1.1
0101:H00195S	WBC	01/01/17 1330	01/01/17 1348	0.3
0101:H00195S	RBC	01/01/17 1330	01/01/17 1348	0.3
0101:H00195S	HGB	01/01/17 1330	01/01/17 1348	0.3
0101:H00195S	HCT	01/01/17 1330	01/01/17 1348	0.3
0101:H00195S	MCV	01/01/17 1330	01/01/17 1348	0.3
0101:H00195S	MCH	01/01/17 1330	01/01/17 1348	0.3
0101:H00195S	MCHC	01/01/17 1330	01/01/17 1348	0.3
0101:H00195S	RDW COEFF VAR	01/01/17 1330	01/01/17 1348	0.3
0101:H00195S	RDW STD DEV	01/01/17 1330	01/01/17 1348	0.3
0101:H00195S	PL CT	01/01/17 1330	01/01/17 1348	0.3
0101:H00195S	MPV	01/01/17 1330	01/01/17 1348	0.3
0101:H00195S	BASO% (AUTO)	01/01/17 1330	01/01/17 1348	0.3
0101:H00195S	EOS% (AUTO)	01/01/17 1330	01/01/17 1348	0.3
0101:H00195S	NEUT% (AUTO)	01/01/17 1330	01/01/17 1348	0.3
0101:H00195S	LYMPH% (AUTO)	01/01/17 1330	01/01/17 1348	0.3
0101:H00195S	MONO% (AUTO)	01/01/17 1330	01/01/17 1348	0.3
0101:H00195S	NRBC	01/01/17 1330	01/01/17 1348	0.3
0101:H00195S	BASO# (AUTO)	01/01/17 1330	01/01/17 1348	0.3
0101:H00195S	EOS# (AUTO)	01/01/17 1330	01/01/17 1348	0.3
0101:H00195S	NEUT# (AUTO)	01/01/17 1330	01/01/17 1348	0.3
0101:H00195S	LYMPH# (AUTO)	01/01/17 1330	01/01/17 1348	0.3
0101:H00195S	MONO# (AUTO)	01/01/17 1330	01/01/17 1348	0.3
0101:H00195S	NRBC# ABSOLUTE	01/01/17 1330	01/01/17 1348	0.3
0101:CD00022S	UR AMPHET	01/01/17 1450	01/01/17 1524	0.5
0101:CD00022S	UR BARBS	01/01/17 1450	01/01/17 1524	0.5
0101:CD00022S	UR BENZOS	01/01/17 1450	01/01/17 1524	0.5
0101:CD00022S	UR CANNABS	01/01/17 1450	01/01/17 1524	0.5
0101:CD00022S	UR COCAINE	01/01/17 1450	01/01/17 1524	0.5
0101:CD00022S	UR METHADONE	01/01/17 1450	01/01/17 1524	0.5
0101:CD00022S	UR OPIATES	01/01/17 1450	01/01/17 1524	0.5
0101:CD00022S	UR PCP	01/01/17 1450	01/01/17 1524	0.5
0101:CD00022S	UR PROPOX	01/01/17 1450	01/01/17 1524	0.5
0101:CD00022S	UR OXYCOD	01/01/17 1450	01/01/17 1524	0.5

Name: KISTNER,JAMES **Date of Birth:** [redacted]60
Med Rec #: [redacted] **Age:** 56 M
Visit #: [redacted] **Insurance:** SP
Arrival: 01/01/17 1135 **Physician:** BILLITTIER,ANTHONY J IV, MD

Full order list

Ordered	Procedure Name	Ordering Provider	E-Signed
01/01/17 1206	IV - Saline Trap	REED,ESSIE M MD, (RES), RE	Yes
01/01/17 1206	Pulse Ox	REED,ESSIE M MD, (RES), RE	Yes
01/01/17 1206	Telemetry - Cardiac Monitor	REED,ESSIE M MD, (RES), RE	Yes
01/01/17 1206	BMP - Basic Metabolic Panel	REED,ESSIE M MD, (RES), RE	Yes
01/01/17 1206	Tox Screen Serum	REED,ESSIE M MD, (RES), RE	Yes
01/01/17 1206	Tox Screen 10 Urine Qual	REED,ESSIE M MD, (RES), RE	Yes
01/01/17 1206	EKG	REED,ESSIE M MD, (RES), RE	Yes
01/01/17 1206	Sodium Chloride 0.9% (Norma...	REED,ESSIE M MD, (RES), RE	Yes
01/01/17 1206	CBC with Auto Diff	REED,ESSIE M MD, (RES), RE	Yes
01/01/17 1206	CT Head Wo IV	REED,ESSIE M MD, (RES), RE	Yes
01/01/17 1445	Tetanus/Diphth/Pertuss (Tda...	BILLITTIER,ANTHONY J IV, MD, ACTIVE	Yes
01/01/17 1514	Discharge Patient	REED,ESSIE M MD, (RES), RE	Yes

Departure

Primary Impression:
Forehead abrasion
Secondary Impressions:
Closed head injury
Disposition: ERIE CTY HOLDING CENTER **Departure Date/Time:** 01/01/17 - 1526
Comment:
Condition: Good

Pt Instructions: Concussion (ED)

Departure Forms: ED Discharge Instructions

Departure Assessments

01/01/17 1520 ER Discharge Screening *JAMIE L WOOD, RN*

Attending MD:
Enter ER Attending: BILLITTIER, ANTHONY MD
Vital Signs:
Temperature (Fahrenheit) 97.9
Heart Rate 73
Respiratory Rate 16
Blood Pressure Systolic 156
Blood Pressure Diastolic 78
SAO2 99
Pain Severity: 0
Patient Instructions:
Demonstrated understanding of instruction by: PT REFUSED VITALS AND TES
Barrier Instruction (defined) NONE
Discharged Patients ONLY********:**
IV site removed and free from redness/swelling? N
Comment NA
Clothing appropriate for the weather? Y
Property with patient? Y
Mode of transport at time of discharge OFFICERS
Accompanied by: OFFICERS X 2

ECMC
ERIE COUNTY MEDICAL CENTER CORPORATION

Patient: KISTNER,JAMES
Account Num: [redacted]
Med Rec Num: [redacted]
Location: EMERGENCY ROOM
Physician: BILLITTIER,ANTHONY J...
Date: 01/01/17

Patient Visit Information

You were seen today for:

Forehead abrasion
Closed head injury

Staff

Your caregivers today were:

Physician	BILLITTIER,ANTHONY J IV, MD
Practitioner	ESSIE M REED
Nurse	AKP

Patient Instructions Reviewed

Concussion

received 01/01/17 - 1520

ED Discharge Instructions

You have received emergency treatment at ECMC. Follow the instructions carefully. **If your condition worsens, or you develop new symptoms, call your follow-up provider for advice.** Call 911 if you are experiencing a medical emergency, otherwise follow up as instructed.

RETURN TO THE ECMC EMERGENCY DEPARTMENT IF YOU HAVE ANY OF THE FOLLOWING SYMPTOMS:

Turn to the emergency department experience persistent headaches, visual changes, numbness or weakness in her arms or legs, the ambulating, or change in urinary or bowel habits

FOLLOW UP WITH:

DISCHARGE INSTRUCTIONS:

as having HIV symptoms or infection and information regarding a Patient's medical

ECMC
ERIE COUNTY MEDICAL CENTER CORPORATION

Patient: KISTNER,JAMES
Account Num: [redacted]
Med Rec Num: [redacted]
Location: EMERGENCY ROOM
Physician: BILLITTIER,ANTHONY J...
Date: 01/01/17

If X-Rays were taken, they were interpreted by an Emergency Physician while you were being treated in the ED. These tests will be reviewed by appropriate specialists the next day.

IF YOU HAVE ANY QUESTIONS ABOUT YOUR CULTURE RESULTS CALL 716-961-7723 AFTER 48 HOURS

Please follow up with your primary care provider for any blood pressure over 120/80 and to review any medication changes during this visit.

****Please give a copy of this information to your primary care provider****

Crisis Hotline Number 716-834-3131(local) and the National Hotline Number 1-800-273-TALK (8255)

ECMC
ERIE COUNTY MEDICAL CENTER CORPORATION

Patient: KISTNER,JAMES
Account Num: [redacted]
Med Rec Num: [redacted]
Location: EMERGENCY ROOM
Physician: BILLITTIER,ANTHONY J...
Date: 01/01/17

Concussion

WHAT YOU SHOULD KNOW:

A concussion is injury to the tissue or blood vessels of the brain. It is also called a closed head injury or mild traumatic brain injury (MTBI). A concussion is usually caused by a bump or blow to the head from a fall, a motor vehicle crash, or a sports injury. Sometimes being forcefully shaken may cause a concussion. A concussion changes how the brain works and should be taken seriously.

INSTRUCTIONS:

Medicines:

- **Ibuprofen or acetaminophen:** These medicines decrease pain. They are available without a doctor's order. Ask your primary healthcare provider which medicine is right for you. Ask how much to take and how often to take it. Follow your primary healthcare provider's directions. These medicines can cause stomach bleeding if not taken correctly. Ibuprofen can cause kidney damage. Do not take ibuprofen if you have kidney disease, an ulcer, or allergies to aspirin. Acetaminophen can cause liver damage. Do not drink alcohol if you take acetaminophen.

- **Take your medicine as directed.** Call your primary healthcare provider if you think your medicine is not helping or if you have side effects. Tell him if you are allergic to any medicine. Keep a list of the medicines, vitamins, and herbs you take. Include the amounts, and when and why you take them. Bring the list or the pill bottles to follow-up visits. Carry your medicine list with you in case of an emergency.

Follow up with your primary healthcare provider as directed: Write down your questions so you remember to ask them during your visits.

Self-care:

- **Have someone wake you regularly during the night:** Ask if someone should wake you at night after your concussion. Ask how often to do this. It is not dangerous to sleep, but you may need to be woken to see if you are thinking clearly. This person should ask you questions such as your name or address.

ECMC
ERIE COUNTY MEDICAL CENTER CORPORATION

Patient: KISTNER,JAMES
Account Num: [redacted]
Med Rec Num: [redacted]
Location: EMERGENCY ROOM
Physician: BILLITTIER,ANTHONY J...
Date: 01/01/17

- **Ice:** Ice helps decrease swelling and pain. Ice may also help prevent tissue damage. Use an ice pack or put crushed ice in a plastic bag. Cover the ice pack with a towel and place it on your head for 15 to 20 minutes every hour for up to 2 days after your injury.

- **Rest:** Rest in bed or do quiet activities for 24 hours after your concussion. You may return to normal activities after your symptoms go away.

- **Activities:** Ask your primary healthcare provider when you can return to work or sports. You should not return to sports until you no longer have symptoms from your concussion.

Contact your primary healthcare provider if:

- You have nausea or vomiting.

- You feel more sleepy than usual.

- Your symptoms get worse.

- You have arm or leg weakness, numbness, or new problems with coordination.

- You have questions or concerns about your condition or care.

Return to the emergency department if:

- You have a severe headache.

- You vomit multiple times

ERIE COUNTY MEDICAL CENTER CORPORATION

Patient: KISTNER,JAMES
Account Num: [redacted]
Med Rec Num: [redacted]
Location: EMERGENCY ROOM
Physician: BILLITTIER,ANTHONY J...
Date: 01/01/17

- Someone tries to wake you and cannot do so.
- You have a seizure, increasing confusion, or a change in personality.
- Your speech becomes slurred, or you have new vision problems.
- You have arm or leg weakness, numbness, or new problems with coordination.
- You have blood or clear fluid coming out of the ears or nose.

MR# [redacted] Account # [redacted] Report# 0101-0682

ERIE COUNTY MEDICAL CENTER CORPORATION
CPEP Medical Screening
462 Grider St.,Buffalo, NY 14215
(716) 898-3000

Patient's Name KISTNER,JAMES
Report# 0101-0682
Date of Birth [redacted]60
Attending Physician:
Dictating Provider: SIMON,MARIE PA-C
Primary Provider: UNKNOWN PRIMARY CARE PROVIDER

MR#: [redacted] **/Account #:** [redacted]
Age/Sex: 56/M
Admission Date/Time:
Admitting Service:
Dictating Date/Time: 01/01/17 1719

History of Present Illness

Allergies/Intolerances:
Coded Allergies:
codeine (Verified Allergy, Unknown, 1/1/17)
History Source: patient, old records
Exam Limitations: no limitations

History of Present Illness

History of Present Illness

Patient is a 56 year old white male with a history of ETOH abuse/depression (2009 admission) who presents to CPEP today on 9.41 papers for evaluation. Patient was seen in medical ED a few hours earlier for medical clearance after patient questionably hit his head. Per earlier visit and per police explanation, patient threw himself on the floor in front of police officers as patient went up to them voluntarily to speak with them, (see previous visit note written by supervising attending.) Patient stated he may have slipped on ice. Patient was brought to med ED for workup including CT scan of head and blood work which were unremarkable. During his visit, patient was agitated and uncooperative. Later patient became cooperative and admitted to doing this for attention. He was discharged in the custody of police, but then within a couple hours returned for CPEP evaluation. Patient is requesting to leave AMA but has been explained he is on 9.41 papers and mandatory assessment is necessary. Patient has a medical history of significant for a tumor removed from his lumbar spine, renal failure, sarcoidosis of his lungs with a medic pneumothorax from a bronchoscopy, kidney stone, lumbago, lipoma, post laminectomy syndrome, bursitis, and osteoarthritis. He states he has a headache from his fall earlier, sob, chest pain, abdominal pain, n/v, f/c. His urine toxicology from today is positive for Cannabis.

Past History

Past History

Handedness: right
Psychosocial History: substance abuse (hx alcohol abuse)
Family History: reviewed/not pertinent
Substance: Positive marijuana, Positive tobacco

Review of Systems

Review of Systems

Negative unless otherwise stated in HPI

Physical Examination

Physical Exam

Vital Signs

Vital Signs

Date Time	Temp	Pulse	Resp	B/P	Pulse Ox	O2 Delivery	O2 Flow Rate	FiO2
1/1/17 16:51	98.2	89	18	172/99				

MR# [redacted] Account # [redacted] Report# 0101-0682

General: alert, oriented X3
HEENT: Atraumatic
Neck: no JVD
Lungs: Clear to auscultation, Normal air movement
Cardiovascular: regular rate & rhythm, pulses are normal
Musculoskeletal: normal gait
Skin: dry & intact
Neuro: no focal deficit

Assessment & Plan
Medically cleared: Yes
Problems:
Additional Comments
A/P:

Psychiatric Evaluation: Defer to primary team

Tobacco use: Nicorette gum PRN

Headache: Tylenol PRN

DRAGON DISCLAIMER: Dragon voice-recognition software may have been used to prepare this typewritten note. Although each note is personally scanned for syntactic or grammatical errors, unintended but conspicuous translational errors can occur. Please contact ECMC if there are any questions about the contents of this note.

SIMON,MARIE PA-C Jan 1, 2017 17:19

Attn Physician:

<Electronically signed by MARIE SIMON PA-C>, 01/01/17 1729

,

,

PC Physician: UNKNOWN PRIMARY CARE PROVIDER
Ref Physician:
Copies To:
~

MR# [redacted] Account # [redacted] Report# 0101-0693

ERIE COUNTY MEDICAL CENTER CORPORATION
NOTES-Psych
462 Grider St.,Buffalo, NY 14215
(716) 898-3000

Patient's Name KISTNER,JAMES
Report# 0101-0693
Date of Birth: [redacted]60
Attending Physician:
Dictating Provider: CUI,XINGJIA MD
Primary Provider: UNKNOWN PRIMARY CARE PROVIDER

MR#: [redacted] **/Account #:** [redacted]
Age/Sex: 56/M
Admission Date/Time:
Admitting Service:
Dictating Date/Time: 01/01/17 1735

General

Chief Complaint: Z-Psychiatric Evaluation
Stated Complaint: 9.41, THREW SELF AT POLICE VEHICLE
Time Seen by MD: 17:32
Comment:
Pt seen and interviewed. Notes reviewed. Briefly, this is a 56 yrs old white male with h/o anxiety disorder and alcohol use disorder, THC abuse, h/o prior CPEP visit, coming to CPEP with 941 paper after voicing SI, with plan to go to motel and drink alcohol to death. He says that he has been sober for four months. Somehow, he was panicky and then suicide thought pops up. On further study, it is found that he went to MED this morning after trying to throw himself over a police car. He was acting odd at MED and then his wife verified that was his baseline. he was not sent CPEP from MED because of that. he was d/ced and then comes back with SI. He is familiar with the CPEP procedure and full eval pending.
Initial assessment completed: Yes

Mental Status Exam

Mental Status Exam

Appearance: no apparent distress
Attitude: cooperative
Behavior: appropriate
Speech: normal rate, normal rhythm, normal volume
Mood Narrative:
"i want anxious"
Mood: anxious
Affect: reactive
Thought Process: organized, goal directed, reality based
Thought Content: REPORTS: suicidal ideations

Cognitive Functioning

Orientation: Oriented to: Person, Place, Time
Intellectual Functioning: intact
Insight: fair
Judgement: fair

CUI,XINGJIA MD Jan 1, 2017 17:35

Attn Physician:

<Electronically signed by XINGJIA CUI MD>, 01/01/17 1740

MR# [redacted] Account # [redacted] Report# [redacted]

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PC Physician: UNKNOWN PRIMARY CARE PROVIDER
Ref Physician:
Copies To:
~

Addendum: CUI,XINGJIA MD on 1/1/17 @ 18:59

first part of triage note was loaded by mistake. please refer to brief psych eval for correction info.

Attn Physician:

<Electronically signed by XINGJIA CUI MD>,01/01/17 1900

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PC Physician: UNKNOWN PRIMARY CARE PROVIDER
Ref Physician:
Copies To:
~

MR# [redacted] Account # [redacted] Report# 0101-0754

ERIE COUNTY MEDICAL CENTER CORPORATION
MH-Mental Health Assessment
462 Grider St.,Buffalo, NY 14215
(716) 898-3000

Patient's Name KISTNER,JAMES
Report# 0101-0754
Date of Birth: [redacted]60
Attending Physician:
Dictating Provider: CUI,XINGJIA MD
Primary Provider: UNKNOWN PRIMARY CARE PROVIDER

MR#: [redacted] **Account #:** [redacted]
Age/Sex: 56/M
Admission Date/Time:
Admitting Service:
Dictating Date/Time: 01/01/17 1858

CPEP RN Triage/Initial

Physician Comments

I have reviewed the above RN documentation. Please see below assessment for details of MD comments.

Brief Assessment

General

Chief Complaint: Z-Psychiatric Evaluation
Time Seen by MD: 18:50
History of Present Illness
Pt seen and interviewed. Notes reviewed. Pt's GF, Rachel, contacted to get collateral info. Briefly, this is a 56 yrs old white single male, father of seven kids, without psych h/x, no h/x alcohol and drug abuse, no prior CPEP visit, coming to CPEp with 941 paper, stating he throwing himself on the police car, for which he categorically denies. He says that he saw two cops car in front of his property. He went to find out why with his son. Cops in the first left without talking to him. He tried to approach the second. In the process, he fell and hurt his head. He was sent to ECMC ER for check up. he was medically clear and then was sent to police station to book in. Thereafter he was sent here. He was not prepared for the event. he has no depression or SI. denies any intention to hurt anyone. he is rational and logic. there is no alcohol and drug abuse issue. There is clearly no indication for acute psych admission. Above info is confirmed with his girlfriend, Rachel. he is going to be d/ced back to home, with MH f/u per his choice.
Brief Emergency Visit complete: Yes
Medically cleared: Yes

Mental Status Exam

Mental Status Exam

Appearance: no apparent distress
Attitude: cooperative
Behavior: appropriate
Speech: normal rate, normal rhythm, normal volume
Mood: anxious
Affect: reactive
Thought Process: organized, goal directed, reality based
Thought Content: REPORTS: suicidal ideations

Cognitive Functioning

Orientation: Oriented to: Person, Place, Time
Intellectual Functioning: intact
Insight: fair
Judgement: fair

MR# [redacted] Account # [redacted] Report# 0101-0754

Risk Assessment

Screening of Suicide Risk

Wish for death/sleep/not wake: No, including last 6 months
Had thoughts of killing self: No, including last 6 months
Access to means: No
Done/started/prepared end life: No
Done something to harm self: No

Chronic/Acute Risk Factors

Risk Factors:
0 (non-factor) Command halluc./30days
0 (non-factor) Depr./loss of interest
0 (non-factor) Extreme anger-current
0 (non-factor) Family Hx of Suicide
0 (non-factor) Feelings of guilt/shame
0 (non-factor) Feelings of hopelessness
0 (non-factor) History of Impulsivity
0 (non-factor) Lack of future plans
0 (non-factor) Lack of support/community
0 (non-factor) Mental Illness/active
0 (non-factor) Recent losses/bad news
0 (non-factor) Substance Withdrawal
0 (non-factor) Trauma/maltreatment

Protective Factors

Protective Factors:
0 (non-factor) Compliant with psy meds:
0 (non-factor) Compliant with psy tx:
0 (non-factor) Cult. discourage suicide:
0 (non-factor) Improved coping skills:
0 (non-factor) Improved mood:
0 (non-factor) Insight into problems:
0 (non-factor) Pos. therap. alliance:
0 (non-factor) Realistic future plans:
0 (non-factor) Rel. discourage suicide:
0 (non-factor) Resilience to stressors:
0 (non-factor) Resolved feeling of loss:
0 (non-factor) Supportivefamily/friends:

Overall Assessment of Risk

To self if discharged home: LOW

Narrative:
He comes to CPEP for throwing himself on police car. There is no lethality issue. He is not depressed and denies any on-going SI. the risk of suicide is low

Harm to Others/Aggressive Beh.

Risk of Harn to Others:
0 (non-factor) Antisoc/Borderline traits
0 (non-factor) Brain Injury (e.g.TBI)
0 (non-factor) Directed anger/hostility
0 (non-factor) Hx of Violence/6 mths
0 (non-factor) Hx/mandated tx for D.V.
0 (non-factor) Hx/mandated tx for anger
0 (non-factor) Impulsivity
0 (non-factor) Subst abuse/withdrawal
0 (non-factor) Violent ideat./past 6 mth

MR# [redacted] Account # [redacted] Report# 0101-0754

Narrative:
he is calm and cooperative. no indication of aggression.
Risk of aggression if DC home: LOW

Treatment Recommendations

Diagnosis

Primary Diagnosis: Adjustment d/o (mixed)

Recommendations

Recommended visit doc: brief visit documentation only

DRAGON DISCLAIMER: Dragon voice-recognition software may have been used to prepare this typewritten note. Although each note is personally scanned for syntactic or grammatical errors, unintended but conspicuous translational errors can occur. Please contact ECMC if there are any questions about the contents of this note.

CUI,XINGJIA MD Jan 1, 2017 18:58

Attn Physician:

<Electronically signed by XINGJIA CUI MD>, 01/01/17 1859

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PC Physician: UNKNOWN PRIMARY CARE PROVIDER
Ref Physician:
Copies To:
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OLV Family Care Center
Catholic Health System
A Department of Mercy Hospital of Buffalo

Office Visit

Patient: KISTNER, JAMES C
DOB: [redacted]60 **Age:** 57 Y **Sex:** Male
PCP: Najmul H Khan

Provider: Gary C. Wysocki, RPA-C
Date: 11/29/2017

Reason for Appointment
1. DSRIP-follow up for shoulder pain

History of Present Illness
HPI:
DSRIP ER f/u, new patient transfer from LSV clinic. Pt presented to ER with 6 weeks of shortness of breath. Exertional dyspnea moreso than at rest. Does have hx of sleep apnea. Does have LE edema. Does get PND. "unsure if he has orthopnea" because of his CPAP/OSA hx. Pt has chest pain regularly. He walked from OLV hospital to our office and had to stop 4-5x. Social situation - has 7 kids at home, 3 in diapers, 2 of which are twins and states spouse has mental health issue and incapable of caring for his children alone for more than 3-4 hours.

Current Medications
Discontinued
- Nicotine Step 1 21 MG/24HR Patch 24 Hour 1 patch to skin Transdermal Once a day
- Claritin 10 mg Tablet 1 tablet Orally Once a day
- Albuterol Sulfate 108 (90 Base) MCG/ACT Aerosol Powder Breath Activated 1 puff as needed Inhalation every 4 hours as needed (prn) for
- Azithromycin 250 MG Tablet 2 tablets on the first day, then 1 tablet daily for 4 days Orally Once a day
- Tessalon Perles 100 mg Capsule 1 capsule as needed Orally Three times a day
- Nicotine 2 MG Gum 1 piece as needed Mouth/Throat 24 time(s) a day
- Nicotine 14 MG/24HR Patch 24 Hour 1 patch to skin Transdermal Once a day
- Atorvastatin Calcium 40 MG Tablet 1 tablet Orally Once a day
- Medication List reviewed and reconciled with the patient

Past Medical History
Sarcoidosis 1981 no follow up.
Schwanomma of spine s/p surgery.
MVA-hit by a car 1/1/2017.

Surgical History
schawnoma tumor lower back (spine)
open lung biopsy-sarcoidosis

Family History
Father: deceased, diagnosed with Hypertension
Mother: alive 87 yrs, diagnosed with Cancer

Paternal Grand Father: deceased
Paternal Grand Mother: deceased
Maternal Grand Father: deceased
Maternal Grand Mother: deceased
3 sister(s) - healthy. 4 son(s) , 3 daughter(s) - healthy.

Social History
Tobacco Use:
Smoking Are you a: former smoker, How long has it been since you last smoked? 1-3 months.
Drug/Alcohol:
Alcohol Did you have a drink containing alcohol in the past year?: No, Points: 0, Interpretation: Negative.
4-6 cigarettes/day x 44 years.

Allergies
Codeine Sulfate: Headaches

Hospitalization/Major Diagnostic Procedure
surgeries

Review of Systems
CHS Review of Systems:
General/Constitutional: no complaints. Cardiovascular: **Positive for:**, chest pain, chest pain with exertion, paroxysmal nocturnal dyspnea, edema. Respiratory: **Positive for:**, shortness of breath, worse with exertion.

CHS Nursing:
Circle of Care: Reviewed and updated with patient.. Abuse Screening: Is there a history of domestic violence?, No, Do you feel safe at home?, Yes, Is anyone hitting/hurting or causing you fear?, No, Are you concerned you might hurt someone?, No. Would you like a chaperone for your exam: Declined. Barriers to Care: No communication barriers noted.

Vital Signs
Ht 69.5, Wt 227.4 lbs, BMI 33.10 Index, Weight Change 17.4 lb, BP 130/90 mm Hg, HR 80, Temp 96.4 F, Pain scale 2 1-10, RR 16.

Examination
General Examination:
Constitutional: in no acute distress. NECK/THYROID: no carotid bruit, no thyroid abnormality, no JVD. CARDIOVASCULAR: regular rate and rhythm, somewhat muffled S1S2, no murmur. RESPIRATORY: clear to auscultation bilaterally, specifically no crackles or wheezes. EXTREMITIES: 2+ pitting edema bilaterally to mid calf. PERIPHERAL PULSES: normal (2+) bilaterally.

Assessments
1. Exertional dyspnea - R06.09 (Primary)
2. Exertional chest pain - R07.9
3. Lower extremity edema - R60.0

Treatment
1. Exertional dyspnea
Imaging: Echocardiogram
Imaging: Exercise Treadmill Stress Test

Clinical Notes: COBRA refusal completed by patient - he declines to go back to ER as directed and only wishes to be assessed as outpatient for cardiac w/u. Needs ECHO and Stress done asap. Advised to call 911 for chest pain/dyspnea. Advised of potential fatal outcome if cardiac problem is at fault. Likelihood angina/CAD vs CHF vs cardiomyopathy.

2. Exertional chest pain
Imaging: Echocardiogram
Imaging: Exercise Treadmill Stress Test

Clinical Notes: as above.

3. Lower extremity edema
Imaging: Echocardiogram
Imaging: Exercise Treadmill Stress Test

Clinical Notes: as above.

4. Others
Clinical Notes: Long discussion with patient. Refuses return to ER for inpatient workup. Aware of potentially fatal outcome and accepts risk.

Follow Up
after stress and echo

Electronically signed by Gary Wysocki , RPA-C on 11/29/2017 at 02:16 PM EST

Sign off status: Completed

Patient: KISTNER, JAMES C **Provider: Gary C. Wysocki, RPA-C**
DOB: [redacted]60 **Date: 11/29/2017**

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Office Visit

Patient: KISTNER, JAMES C
Account Number: [redacted] **External MRN:** [redacted]
DOB: [redacted]60 **Age:** 58 Y **Sex:** Male
Phone: 716-895-2949
Address: 33 SCHMARBECK AVE, BUFFALO, NY-14212
Patient's Default Facility: OLV Familycare Center

Provider: Najmul H. Khan, DO
Date: 06/29/2018
CHN#: [redacted]

Subjective:

Chief Complaints:
1. DSRIP-follow up fo shoetness of breath.

HPI:
Depression Screening:
PHQ-2 In last two weeks have you been bothered by Little interest or pleasure in doing things No, Feeling down, depressed, or hopeless No.
HPI:
\This is a 58 years old Caucasian male came to the office for emergency room follow-up. Patient was in the emergency room with severe shortness of breath, swelling of bilateral lower extremities. Patient has a past medical history significant for obstructive sleep apnea, chronic, metastatic disease of the lung, chronic obstructive pulmonary disease, hypercholesterolemia. Patient had the echocardiogram done in 2017 which showed normal ejection fraction 60% and no cardiac structural abnormality. Electrocardiogram done in the emergency room shows normal sinus rhythm no sign of acute coronary disease, patient was seen by Dr. Buscaglia pulmonologist and was told that most likely patient has no sarcoidosis on chronic obstructive pulmonary disease. Patient last lipid profile shows total cholesterol is 217 and LDL of 204. Patient is complaining of severe shortness of breath with mild exertion. I will order the echocardiogram on the and start the patient on furosemide 40 mg 1 tablet daily I will see the patient in 2 weeks.

ROS:
CHS Review of Systems:
General/Constitutional: no complaints. ENT: no complaints, Negative for:, hearing loss, congestion. Cardiovascular: no complaints, Negative for:, chest pain, dyspnea with exertion, edema, palpitations. Respiratory: no complaints, Negative for:, cough, shortness of breath. Gastrointestinal: no complaints, Negative for:, nausea, vomiting, diarrhea, constipation, pain in abdomen. Genitourinary: no complaints, Negative for:, dysuria, urinary frequency. Musculoskeletal: no complaints, Negative for:, joint pain, joint swelling, joint stiffness, muscle pain. Neurological: no complaints, Negative for:, headache, seizures, motor/sensory loss. Psychiatric: no complaints, Negative for:, anxiety, depression, suicidal ideations. Dermatologic: no complaints, Negative for:, rash, lesion(s), lumps.
CHS Nursing:
Circle of Care: Reviewed and updated with patient.. Abuse Screening: Is there a history of domestic violence?, No, Do you feel safe at home?, Yes, Is anyone hitting/hurting or causing you fear?, No, Are you concerned you might hurt someone?, No. Would you like a chaperone for your exam: Declined. Barriers to Care: No communication barriers noted. Documented By: Barbara Walh LPN.

Medical History: Sarcoidosis 1981 no follow up, Schwanomma of spine s/p surgery, MVA-hit by a car 1/1/2017, Acute bronchitis, Routine adult health maintenance, Wrist pain, Adjustment disorder, Lower extremity edema.

Surgical History: schawnoma tumor lower back (spine) , open lung biopsy-sarcoidosis .

Hospitalization/Major Diagnostic Procedure: surgeries , CP-Observation 11/30/2017.

Family History: Father: deceased, diagnosed with Hypertension. Mother: alive 87 yrs, diagnosed with Cancer. Paternal Grand Father: deceased. Paternal Grand Mother: deceased. Maternal Grand Father: deceased. Maternal Grand Mother: deceased. 3 sister(s) - healthy. 4 son(s) , 3 daughter(s) - healthy. .

Social History:
Tobacco Use: Smoking Are you a: former smoker, How long has it been since you last smoked? 6-12 months.

Social Determinants of Health: Screening Do you find it difficult to interact with others or maintain an adqueate social life? No, Do you find it difficult to meet the daily needs of food, housing, or transportation? No, Date Performed: 01/08/2018, Documented by: Diane Miesowicz,MA .
DAST 1: Screening Completed Date: 06/29/2018, In the past 12 months, have you used drugs other than those required for medical reasons? No.
Drug/Alcohol: Alcohol Did you have a drink containing alcohol in the past year? No, Points 0, Interpretation Negative.
4-6 cigarettes/day x 44 years Lives alone, significant other and children live next door, independent with ADL, does not drive, uses public transportation or gets a ride.

Medications: Taking Ventolin HFA 108 (90 Base) MCG/ACT Aerosol Solution 2 puffs as needed Inhalation every 6 hrs, Taking Advair Diskus 250-50 MCG/DOSE Aerosol Powder Breath Activated 1 puff Inhalation Twice a day, Taking Atorvastatin Calcium 40 MG Tablet 1 tablet Orally Once a day, Discontinued PrednISONE 20 MG Tablet 2 tablet Orally Once a day, Medication List reviewed and reconciled with the patient

Allergies: Codeine Sulfate: Headaches.

Objective:

Vitals: Ht 69.5, Wt 244.4 lbs, BMI 35.57 Index, Weight Change 13 lb, BP 128/84 mm Hg, HR 84, Temp 97.8 F, Pain scale 4 1-10, RR 20.

Examination:
General Examination:
Constitutional: in no acute distress, looks well. EYES: bilateral conjunctivits with sever tearing of the eyes. HEENT: HEAD:, atraumatic, normocephalic, EARS:, tympanic membranes normal, EYES:, clear conjuctiva, Extra Ocular Muscles Intact (EOMI), Pupils Equal, Round, Reactive to Light and Accommodation (PERRLA), NOSE:, nose clear, THROAT:, throat clear. ORAL CAVITY: unremarkable. NECK/THYROID: no carotid bruit, no thyroid abnormality. CARDIOVASCULAR: regular rate and rhythm, normal S1S2. RESPIRATORY: clear to auscultation bilaterally. NEUROLOGIC EXAM: alert, oriented, no gross motor/sensory deficit. SKIN: no rash or skin lesions. EXTREMITIES: 2+ BL edema.

Assessment:

Assessment:
1. Abdominal discomfort - R10.9 (Primary)
2. Allergic conjunctivitis, unspecified laterality - H10.10
3. SOB (shortness of breath) - R06.02
4. Leg edema - R60.0

Plan:

1. Abdominal discomfort
Imaging: Ultrasound : Abdomen and Pelvis
Bonafede,Danielle 06/29/2018 02:34:07 PM EDT > pls obtain prior auth for above test...would like to go to mercy hospital of buffalo

2. Allergic conjunctivitis, unspecified laterality
Start Cromolyn Sodium Solution, 4 %, 1 drop into affected eye, Ophthalmic, Four times a day, 30 days, 1, Refills 2 ; Start Zyrtec Allergy Tablet, 10 MG, 1 tablet, Orally, Once a day, 30 day(s), 30, Refills 2 .

3. SOB (shortness of breath)
Imaging: Echocardiogram
Bonafede,Danielle 06/29/2018 02:35:16 PM EDT > pls obtain prior auth for above test...would like to go to mercy hospital

4. Leg edema
Start Lasix Tablet, 40 MG, 1 tablet, Orally, Once a day, 30 day(s), 30, Refills 0 .
Imaging: Echocardiogram
Bonafede,Danielle 06/29/2018 02:35:16 PM EDT > pls obtain prior auth for above test...would like to go to mercy hospital

Follow Up: 4 Weeks

Provider: Najmul H. Khan, DO
Patient: KISTNER, JAMES C **DOB:** [redacted]50 **Date:** 06/29/2018

Electronically signed by Najmul Khan , DO on 07/01/2018 at 12:40 AM EDT
Sign off status: Completed

Office Visit

Patient: KISTNER, JAMES C
Account Number: [redacted] **External MRN:** [redacted]
DOB: [redacted]60 **Age:** 58 Y **Sex:** Male
Phone: 716-895-2949
Address: 33 SCHMARBECK AVE, BUFFALO, NY-14212
Patient's Default Facility: OLV Familycare Center

Provider: Najmul H. Khan. DO
Date: 07/12/2018
CHN#: [redacted]

Subjective:

Chief Complaints:
1. 2 WEEK FOLLOWUP US/ECHO. 2. U/s done 7/6/18 and printed.

HPI:
HPI:
this is a 58 years old very pleasant Caucasian male came to the office for 2 week follow-up patient was seen by me after the hospital discharge follow-up. Patient was complaining of severe shortness of breath and swelling of bilateral lower extremities at the time of the last visit. I started the patient on Lasix 40 mg daily also at the time of the patient visit last time patient had the allergic conjunctivitis I started the Coumadin patient never got the medication but just started taking Zyrtec patient now feeling much better. Patient had the echocardiogram done which showed that patient left ventricular ejection for normal 55-60% with impaired left ventricular diastolic relaxation, patient also has mild aortic root dilatation.

Patient had the ultrasound of the abdomen done which showed that patient has fatty liver, enlarged prostate. Patient lost about 5 pounds during last 2 weeks which is most likely water weight, patient will continue same medication I will start him on Advair and Ventolin inhaler.

ROS:
CHS Review of Systems:
General/Constitutional: no complaints. ENT: no complaints, Negative for:, hearing loss, congestion. Cardiovascular: no complaints, Negative for:, chest pain, dyspnea with exertion, edema, palpitations. Respiratory: no complaints, Negative for:, cough, shortness of breath. Gastrointestinal: no complaints, Negative for:, nausea, vomiting, diarrhea, constipation, pain in abdomen. Genitourinary: no complaints, Negative for:, dysuria, urinary frequency. Musculoskeletal: no complaints, Negative for:, joint pain, joint swelling, joint stiffness, muscle pain. Neurological: no complaints, Negative for:, headache, seizures, motor/sensory loss. Psychiatric: no complaints, Negative for:, anxiety, depression, suicidal ideations. Dermatologic: no complaints, Negative for:, rash, lesion(s), lumps.

Medical History: Sarcoidosis 1981 no follow up, Schwanomma of spine s/p surgery, MVA-hit by a car 1/1/2017, Acute bronchitis, Routine adult health maintenance, Wrist pain, Adjustment disorder, Lower extremity edema.

Surgical History: schawnoma tumor lower back (spine) , open lung biopsy-sarcoidosis .

Hospitalization/Major Diagnostic Procedure: surgeries , CP-Observation 11/30/2017.

Family History: Father: deceased, diagnosed with Hypertension. Mother: alive 87 yrs, diagnosed with Cancer. Paternal Grand Father: deceased. Paternal Grand Mother: deceased. Maternal Grand Father: deceased. Maternal Grand Mother: deceased. 3 sister(s) - healthy. 4 son(s) , 3 daughter(s) - healthy. .

Medications: Taking Ventolin HFA 108 (90 Base) MCG/ACT Aerosol Solution 2 puffs as needed Inhalation every 6 hrs, Taking Advair Diskus 250-50 MCG/DOSE Aerosol Powder Breath Activated 1 puff Inhalation Twice a day, Taking Atorvastatin Calcium 40 MG Tablet 1 tablet Orally Once a day, Taking Zyrtec Allergy 10 MG Tablet 1 tablet Orally Once a day, Taking Lasix 40 MG Tablet 1 tablet Orally Once a day, Discontinued Cromolyn Sodium 4 % Solution 1 drop into affected eye Ophthalmic Four times a day, Medication List reviewed and reconciled with the patient

Allergies: Codeine Sulfate: Headaches.

Objective:

Vitals: Ht 69.5, Wt 239 lbs, BMI 34.78 Index, Weight Change -5.4 lb, BP 122/80 mm Hg, HR 80, Temp 98.4 F, Pain scale 4 1-10, RR 18.

Examination:

General Examination:

Constitutional: In no acute distress, looks well. CARDIOVASCULAR: regular rate and rhythm, normal S1S2. RESPIRATORY: clear to auscultation bilaterally. GASTROINTESTINAL: soft, non-tender/non-distended, bowel sounds present. NEUROLOGIC EXAM: alert, oriented, no gross motor/sensory deficit. PSYCH appropriate mood and affect . SKIN: no rash or skin lesions. EXTREMITIES: no clubbing, cyanosis, or edema. PERIPHERAL PULSES: normal (2+) bilaterally.

Assessment:

Assessment:

1. Chronic obstructive pulmonary disease, unspecified COPD type - J44.9 (Primary)
2. Leg edema - R60.0
3. Sarcoidosis - D86.9
4. Dependence on other enabling machines and devices - Z99.89
5. Obstructive sleep apnea (adult) (pediatric) - G47.33
6. Hypercholesteremia - E78.00

Plan:

1. Chronic obstructive pulmonary disease, unspecified COPD type

Refill Ventolin HFA Aerosol Solution, 108 (90 Base) MCG/ACT, 2 puffs as needed, Inhalation, every 6 hrs, 30 days, 1, Refills 5 ; Refill Advair Diskus Aerosol Powder Breath Activated, 250-50 MCG/DOSE, 1 puff, Inhalation, Twice a day, 30 days, 1, Refills 5 .

Clinical Notes: Encouraged to continue to use the inhaler as prescribed. If use were to increase or new symptoms were to develop proceed to ER or call office.

2. Leg edema

Refill Lasix Tablet, 40 MG, 1 tablet, Orally, Once a day, 30 day(s), 30, Refills 5 .

3. Hypercholesteremia

Refill Atorvastatin Calcium Tablet, 40 MG, 1 tablet, Orally, Once a day, 30 day(s), 30, Refills 5 .

Clinical Notes: Discussed the importance of low fat diet, goal LDL is less than 100. Warned of the common side effects of statin including myalgia and increased liver enzymes. If symptoms were to occur cal office.

4. Others

Clinical Notes: Assessed patients understanding of medications, assessed patients response to medications and any barriers to adherence., Patient was provided information about new medication(s) including potential side effects, drug interactions, instructions for taking the medication(s), and the consequences of not taking the medication(s). Patient verbalizes understanding.

Follow Up: 3 Months

Provider: Najmul H. Khan. DO
Patient: KISTNER, JAMES C **DOB:** [redacted]60 **Date:** 07/12/2018

Electronically signed by Najmul Khan , DO on 07/19/2018 at 09:45 PM EDT
Sign off status: Completed